JB Pritzker, *Governor*

IDHS
ILLINOIS DEPARTMENT OF HUMAN SERVICES

Dulce M. Quintero, *Secretary*

100 South Grand Avenue, East • Springfield, Illinois 62762
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DATE: February 10, 2026

MEMORANDUM

TO: The Honorable Don Harmon, Senate President
The Honorable John F. Curran, Senate Minority Leader
The Honorable Emanuel "Chris" Welch, Speaker of the House
The Honorable Tony McCombie, House Minority Leader

FROM: Inger Burnett-Zeigler
Chief Behavioral Health Officer
Illinois Department of Human Services

SUBJECT: Administrative Burden Task Force

The Illinois Department of Human Services respectfully submits the *Administrative Burden Task Force Report* on behalf of the Chief Behavioral Health Officer in order to fulfill the requirements set forth in Public Act 103-0690.

If you have any questions or comments, please contact Dr. Inger Burnett-Zeigler, Chief Behavioral Health Officer, at Inger.Burnettzeigler@illinois.gov.

cc: The Honorable JB Pritzker, Governor
John W. Hollman, Clerk of the House
Tim Anderson, Secretary of the Illinois Senate
Legislative Research Unit
State Government Report Center

Administrative Burden Task Force Report

February 10, 2026

Report Contents

DR. INGER BURNETT-ZEIGLER
CHIEF BEHAVIORAL HEALTH OFFICER

Letter from the Chair

I would like to extend my sincere gratitude to the members of the Administrative Burden Task Force (ABTF) for their extraordinary commitment, expertise, and service to the State of Illinois. The members of the Workforce Direct Care Expansion Act's ABTF were charged with the responsibility to examine administrative policies, regulations, and practices within Illinois' behavioral health system and to identify inefficiencies, duplicative requirements, and unnecessary barriers that detract from timely, high-quality, client-centered care.

From February 2025 through January 2026, ABTF members dedicated substantial time and thoughtful engagement to this work. The Task Force brought together a broad range of perspectives and professional experience from across the behavioral health service delivery system, including providers, trade associations, state department staff, and legislative leaders. This diverse representation strengthened the Task Force's deliberations and ensured that its recommendations were informed by both policy considerations and on-the-ground realities faced by providers, staff, and individuals seeking care.

I would like to recognize the at participation in the ABTF required members to balance this responsibility alongside demanding professional roles. Members contributed their experience, insight, and problem-solving skills with a shared understanding that excessive administrative burden contributes to clinician burnout, workforce instability, and inequitable access to care. Their work reflects a collective commitment to improving system efficiency, strengthening the behavioral health workforce, and advancing better outcomes for Illinois residents.

This report reflects the seriousness with which ABTF members approached their charge. I hold a deep appreciation for the contributions of every member of the Task Force and wish to recognize their leadership, diligence, and dedication to building a more effective, sustainable, and equitable behavioral health system in Illinois.

Sincerely,

Chief Dr. Inger Burnett-Zeigler

Member List

Heather Ast
Chris Balkema
Stephanie Barisch
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Blanca Campos
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Jackie Haas
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Eugene Humphrey
Lindsey LaPointe
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Emily Miller
Dr. Forrest Moore
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Meredith O'Brien
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Matt Picket
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Executive Summary

The primary purpose of the Administrative Burden Task Force (ABTF) report is to present recommendations developed by the ABTF members to reduce duplicative or unnecessary administrative requirements within the behavioral health system in accordance with Public Act 103-0690: Workforce Direct Care Expansion Act in Illinois (2024). This report serves as a formal mechanism for documenting the ABTF's methodology, identifying administrative challenges, and outlining recommendations to reduce administrative burdens for behavioral health providers in Illinois.

This report is intended to inform and guide Illinois Health and Human Services (IHHS) departments, policymakers, and other interested parties by clearly and publicly presenting issues experienced by behavioral health providers and recommending next steps. Consistent with statutory requirements, relevant IHHS departments are expected to review the recommendations and provide public responses within 90 days, including assessments of feasibility, implementation approaches, and anticipated impacts.

Background

As outlined in Public Act 103-0690 (PA 103-0690) (the "Act"), the Workforce Direct Care Expansion Act in Illinois (2024)[i] administrative tasks were identified as a burdens impacting behavioral health professionals and recognizing that reducing these burdens may yield positive outcomes, such as supporting timely access to high-quality, client-centered care, strengthening workforce sustainability, and enabling providers to devote more time to direct service delivery and improving outcomes for residents. The Act also notes that failing to address these burdens reduces staff time for treatment, contributes to clinician burnout, and leads to workforce challenges, ultimately affecting timely care, costs, and health equity. The ABTF was charged with reviewing policies and regulations in the behavioral health sector to identify inefficiencies, duplicative requirements, unduly burdensome restrictions, and administrative barriers.

Administrative Burden Task Force Membership

The Act established the ABTF within the Office of the Chief Behavioral Health Officer (CBHO) in partnership with the Illinois Department of Human Services' Division of Behavioral Health & Recovery (IDHS-DBHR),[ii] the Department of Children and Family Services (DCFS), the Illinois Department of Healthcare and Family Services (HFS), and the Department of Public Health (IDPH). The CBHO appointed Illinois State Representative Lindsey LaPointe as co-chair. Minimum requirements for the ABTF membership were outlined in Section 15[iii] of the Act.

As chair, the Illinois' CBHO invited representatives to serve on the ABTF, meeting the statutory minimum of 15 members. Members were required to include community mental health and substance use providers from across the state, representatives of statewide behavioral health associations, advocacy organizations led by or primarily consisting of individuals with lived experience, and representatives from IDHS-DBHR, DCFS, and IDPH. Required legislative representation includes one House member appointed by the Speaker, one House member appointed by the Minority Leader, one Senate member appointed by the Senate President, and one Senate member appointed by the Minority Leader.

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[i] Workforce Direct Care Expansion Act (P.A. 103-690)

[ii] On July 1st, 2025, the Division of Mental Health (DMH) and the Division of Substance Use Prevention and Recovery (SUPR) merged to form a single division, the Division of Behavioral Health and Recovery (DBHR). The legislation references DMH and SUPR but for the purpose of this plan, are referenced to as DBHR.

[iii] Illinois Compiled Statutes, 405 ILCS 162/15 (2024), *Membership* (as amended by P.A. 103-690 and P.A. 103-1075).

In 2024, the CBHO issued invitations to 35 individuals to become potential members of the ABTF, all of whom accepted. The full membership list appears in Table 3 of the appendix. Chief Inger Burnett-Zeigler began chairing ABTF meetings starting in February 2025.[iv]

Relevant State Reports

The Act requires research on best practices for administrative burden reductions from other states. The University of Illinois System's Office of Medicaid Innovation (OMI) with direction from the CBHO, conducted research and identified three reports from Oregon[Error! Bookmark not defined.], Virginia[Error! Bookmark not defined.], and San Diego County[Error! Bookmark not defined.]. These reports highlight similar administrative burdens including duplicative data entry, excessive documentation, challenges with licensure, certification and credentialing, and complex regulatory requirements. These challenges were particularly acute for publicly funded providers, rural and underserved communities, and culturally and linguistically specific populations.

Common strategies to address these challenges included streamlining and standardizing documentation, aligning regulatory requirements across agencies and funding streams, leveraging technology to automate data collection, engaging multi-stakeholder task forces, investing in workforce development and training, and implementing policy and legislative reforms focused on outcome measures, parity, and funding alignment. Table 1 provides a high-level overview of the purpose and recommendations of the three identified reports.

Table 1. Relevant State Reports Overview

Jurisdiction	Purpose	Recommendations[v]
Oregon (2025)[vi]	To examine major barriers to recruitment and retention in Oregon's public behavioral health system and develop recommendations to address the workforce crisis, focusing on several key areas, including but not limited to improving retention, reducing administrative burden and workload, and implementing provisions under HB 2235.	• Conduct a gap analysis and streamline licensing processes using clear, standardized procedures. • Enhance clinical supervision by implementing consistent training and formal guidelines. • Lower financial barriers through subsidized licensing, credentialing, and educational opportunities. • Build a stronger clinical supervision framework with comprehensive support for supervisors. • Minimize provider burnout by setting caseload limits and providing additional support resources. • Consolidate Community Care Organization credentialing to remove duplicate processes. • Reduce documentation requirements by applying medical field standards and using uniform templates.

[iv] See the appendix section for the full list of membership.

[v] *Recommendations have been paraphrased for clarity and reflect those most relevant to this report; the list is not exhaustive.*

[vi] House Bill 2235 (2023) required the Oregon Health Authority to convene a workgroup to study major barriers to workforce recruitment and retention in Oregon's publicly funded behavioral health system and to develop recommendations for improvement. The work group provided formal recommendations for OHA to submit to the Oregon Legislature, with the initial report due January 15, 2025, and the final report due December 15, 2025.

Virginia (2025)[vii]	Objective 2 of the 2024 Special Session 1 Appropriations Act required the Department of Behavioral Health and Development Services to identify and report on the administrative burdens that Community Services Boards (CSBs) face and eliminate those requirements.[vii]	• Establish clearer expectations for documentation by providing standardized formats and templates, helping to reduce administrative burden and ensure consistency across providers. • Provide structured on-the-job training and technical assistance to support staff, particularly those new to the field, in understanding state-level review processes and regulatory expectations. • Encourage collaboration among executive, legislative, and regulatory bodies to develop a cohesive strategy for reducing administrative burden across billing, licensing, reimbursement, and certification. • Map regulations and documentation to their responsible governing bodies. • Simplify and standardize requirements for mandatory documentation. • Provide clear guidance and consistent communication on service expectations, such as the use of the Comprehensive Needs Assessment during Same Day Access.
San Diego County (2022)[viii]	Quantify the region's behavioral health workforce shortage and identify structural contributors, outline a long-term regional vision for retaining, developing, and attracting qualified staff, and identify initiatives that can accelerate progress on the ground, addressing factors such as, but not limited to, administrative burden, burnout, turnover, and unmet service demand.	• Reduce administrative burden and workload by reforming documentation, reconciling overlapping requirements, and simplifying both clinical and administrative forms with streamlined regulatory expectations. • Invest in competitive compensation to stem workforce losses and improve recruitment. • Establish regional training hubs to strengthen professional development and expand the pipeline into behavioral health roles. • Engage frontline staff regularly to identify emerging barriers and improve retention strategies

These reports make clear that the challenges experienced by Illinois providers are shared nationally. Further, the recommendations that are put forth in the report are in alignment with those developed by the ABTF

[vii] Report on the Administrative Burden on Community Services Boards – June 26, 2025; Community Service Boards serve as a single point of entry into publicly funded mental health, developmental, and substance abuse service.
[viii] Addressing San Diego's behavioral workforce shortage - San Diego Workforce Partnership

Issues and Recommendation Development Process

Beginning in February 2025, the ABTF held monthly public meetings to identify and address administrative burdens experienced by behavioral health providers in Illinois. Between the first and second meetings, the CBHO designed and disseminated a survey to identify areas of administrative burden from the perspective of behavioral health providers, clients, or any other interested stakeholders. Forty-two individuals responded, with 62% from the ABTF and 38% from public commenters. Two-thirds of respondents identified as behavioral health service providers.

A qualitative analysis of the survey results identified seven primary themes (see Table 2). Each monthly meeting focused on one or two primary themes, identifying and detailing the issues, and drafting recommendations. The meeting topics were ordered from most frequently mentioned to least. Some meetings were dedicated to reviewing previously compiled recommendations across multiple themes. A master document was developed that included the primary themes, subthemes, detail of the issue and recommendations. Feedback from the monthly meetings was used to iteratively revise the master document.

In addition to standard meetings, Illinois' Health and Human Services (IHHS) Departments including HFS, IDHS, IDPH and DCFS, met with the CBHO to assess the feasibility, impacts, alignment with current or past projects, and related details. This process ensured that proposed issues and solutions were fully understood by government partners, provided opportunities to bring questions back to the ABTF, and supported the identification of actionable next steps.

The following page includes Table 2, which lists the meeting dates and discussion themes.

Table 3. Administrative Burden Priority Survey Themes, Definitions, and Meeting Date

Theme	Description	Meeting Date
1. Clinical Documentation	Requirements related to completing and maintaining clinical records, including client registration, assessment and treatment plans, progress notes, and other documentation needed to support high-quality, person-centered care while meeting regulatory and payer requirements.	April 21, 2025
2. Guidance and Rules	The policies, regulations, and administrative guidelines that govern service delivery, include administrative rules and grant processes.	May 19, 2025
3. Uses of Technology	The technological tools and systems used to deliver and document services, including data-transmission requirements, portals for communication with payers and IHHS departments, and challenges stemming from outdated or incompatible technology platforms.	June 21, 2025
• *Review Session*	*Review Recommendations from themes 1-3.*	*July 21, 2025*
4. Billing and Claiming	Processes for Medicaid billing and claiming, such as meeting continued stay criteria, prior authorization requirements, and service note documentation standards.-stay criteria, prior authorization requirements	August 18, 2025
5. Data and Reporting	Requirements related to collecting, reporting, and submitting mandated data elements, often across multiple systems, to demonstrate compliance, monitor outcomes, and support planning and quality improvement efforts.	September 15, 2025
6. Audits and Accreditations & 7. Operational Barriers	Audits & Accreditations: Oversight processes such as annual attestations, external accreditation reviews, provider entity re-certification cycles, and audits conducted by IHHS departments or independent bodies to ensure compliance with regulatory and quality standards. Operational Capacity: Day-to-day administrative and workforce related requirements such as onboarding procedures, background checks, staff training mandates, professional credentialing, and contracting activities that impact organizational capacity.	October 20, 2025
• *Review Session*	*Review Recommendations from themes 4-6.*	*November 17, 2025*
• *Review Session*	*Review all recommendations to date.*	*December 15, 2025*
• *Report Draft Review*	*Final review of recommendations to date.*	*January 26, 2026*

Administrative Burden: Key Issues & Recommendations

The following issue summaries were developed following the recording and organizing of issues raised by the ABTF with recommendations being developed in close collaboration with the relevant IHHS Departments. Some issues raised within the context of the ABTF discussions may be addressed directly within the report, while other issues are noted as out of scope or redirected to another party for further consideration and listed in the appendix of this document. The intent of the summary below is to capture the issues and recommendations that have the largest impact on most behavioral health providers and present actionable next steps. The issues and recommendations below will require various combinations of effort from IHHS Departments and behavioral health stakeholders.

An implementation plan, inclusive of department leads and resource allocation will be developed as a next step following the release of this report.

The final issues and recommendations were organized into nine topic areas or issue statements addressing the following:

1. Medicaid Managed Care Prior Authorizations and Post-Payment Review
2. Medicaid Billing and Claiming
3. Certification and Licensure of Behavioral Health Providers
4. Integrated Behavioral Health Service Delivery
5. Behavioral Health Crisis Services Funding
6. Monitoring and Oversight of Behavioral Health Providers
7. Data Collection, Submission and Reporting
8. Technology Enhancements
9. Provider-to-Payer Communications

Extended Efforts: Recognizing the extensive contributions and commitment from the ABTF members throughout the ABTF process, the CBHO acknowledges the need to ensure continuity in these efforts beyond the conclusion of the legislative requirements of the Act. As a result, in certain recommendations that follow, the CBHO has identified the need to organize the IHHS Departments and stakeholder in ongoing dialogue and administrative simplification, as specifically detailed below.

1. Medicaid Managed Care Prior Authorizations and Post-Payment Review

Issue: Variation in Medicaid Managed Care Organizations' (MCO) prior authorization and post-payment review requirements for behavioral health services creates administrative complexity for providers, impacts service capacity, and presents challenges to timely and consistent access to care.

Overview:
Behavioral health providers who are already struggling to navigate Illinois' fragmented behavioral health administrative structures are further frustrated by the administrative burden created by working with State's Medicaid MCOs. Similar to the challenges created by state registration systems, Medicaid MCO requirements to utilize prior authorization and immediate notification protocols are administrative requirements that impact access to care and can reduce clinician service capacity.

Examples of this challenge include:

- Inconsistent prior authorization requirements between HFS fee-for-service and Medicaid MCO-funded service reimbursement
- Medicaid MCO staff receiving and reviewing utilization requests may fail to meet the same clinical credentials as provider staff seeking service approval
- Inconsistencies in Medicaid MCO post payment review protocols

Impact to providers:

- As many providers do not have dedicated utilization teams, providers must spend clinical time justifying medical necessity for services, depending upon which Medicaid payer and service, eroding service delivery and impacting access to care
- Different prior authorization and post payment review protocols require providers to implement multiple mitigation strategies increasing operational complexity
- Inconsistent application of post payment reviews by Medicaid MCOs can make adverse findings seem arbitrary and random

Recommendations:
Since the introduction of Medicaid managed care in Illinois, HFS has made great strides in its efforts to coordinate the Medicaid MCO-delivered care with its enrolled behavioral health providers. Furthermore, the State recognizes that utilization review is a federal requirement of the Medicaid program and HFS continues to work with its contracted health plans on the implementation of PA 103-0650, including adopting the administrative rule on Hospital Managed Care Utilization Review Standardization and Transparency Practices.

Therefore, it is recommended that HFS work with its contracted Medicaid MCOs to:

- Standardize Medicaid prior authorization and post-payment review for behavioral health services and related implementing or interpretive guidance, where permitted by federal law;
- Establish standing agenda items on existing Joint Accountability Provider-Medicaid Managed Care meetings to provide updates on utilization management alignment efforts and as spaces to collect ongoing provider feedback related to challenges experienced with utilization management processes;

- Review prior authorization and post-payment review practices during quarterly meetings to ensure consistency and quality; and

- Promote, when feasible, that Medicaid MCOs explore alternative forms of utilization review with providers that may reduce impacts upon provider operations, including continuity across Medicaid Managed Care and Medicaid Fee for Service healthcare delivery, ultimately strengthening coordination with community-based behavioral health providers.

2. Medicaid Billing and Claiming

Issue: Illinois' Medicaid behavioral health program's complex provider definitions, service structures, documentation standards, and fee schedules create operational challenges for providers, particularly those working across Medicaid, private insurance, and Medicare, contributing to administrative complexity, reimbursement difficulties, and barriers to service access.

Overview:
Illinois' Medicaid program is generally organized by federal Medicaid authority (e.g. Medicaid Rehab Option, Other Licensed Practitioner) which results in the State's definition of eligible provider types (e.g. community mental health centers, substance use providers, independent practitioners, physicians) and allowable services. When possible, HFS tries to recognize and leverage common statutes and regulatory frameworks (e.g. provider practice acts, Substance Use Disorder [SUD] licensure act) to reduce inconsistencies and burden across its regulatory requirements. However, HFS is also allowed to expand access by creating providers and services that meet the unique needs of the state through its state plan, regulations, policies, and fee schedules. Providers such as Community Mental Health Centers (CMHCs), substance use providers, Behavioral Health Clinics (BHCs), and Certified Community Behavioral Health Clinics (CCBHCs) can leverage a variety of non-licensed clinical staff to deliver a broad array of behavioral health services and supports that are uniquely defined within the Illinois Medicaid structure. Providers are often challenged to understand the nuances related to the certification, service requirements, documentation, and payment differences between these provider types. These challenges can create operational hurdles for providers when attempting to work with private insurance plans that can have vastly different contractual requirements from the State's Medicaid program. These differences can be further complicated by Medicaid requirements related to third-payer liability (TPL) and the fact that private insurance, and in some cases Medicare, may not recognize or reimburse providers consistent with Illinois' Medicaid program.

Examples of this challenge include:
- Navigating multiple Medicaid fee schedules, provider handbooks, and provider notices increases operational complexity
- Differences in documentation standards between Medicaid and private insurance can increase documentation time for clinical staff and add operational complexity
- Medicaid standards for TPL can be confusing, complex and repetitive, increasing the amount of effort required to seek reimbursement for customers that have Medicaid as a secondary coverage
- State defined service array is broad and requires increased effort to effectively code service nuance and ensure adequate reimbursement
- The complexity of Medicaid keeps many private providers from enrolling, limiting service access

Impact to providers:

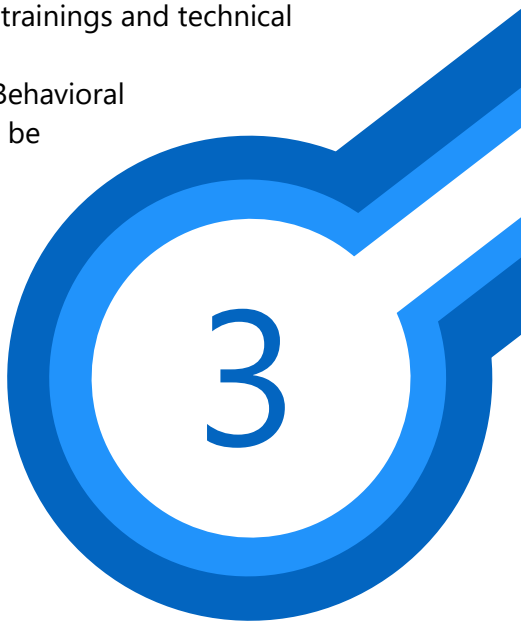
- While certain provider types exist primarily as a product of the State's Medicaid program (i.e. BHCs, CMHCs, CCBHCs), providers seeking to navigate state funding and private insurance funding are required to establish and maintain increased capacity in their business offices and technical platforms to manage the nuance of private insurance and state funded service delivery and reimbursement requirements
- While the vast array of services supports the needs of clients, coding nuances in the Medicaid fee schedule create complexity
- Service documentation requirements of private insurance may not be consistent with federal Medicaid standards of establishing medical necessity creating confusion and potentially extra effort from clinicians to document care

Recommendations:

It is recommended that HFS:

- Review its regulatory requirements regarding service delivery and documentation and leverage its Medicaid Technical Assistance Center (MTAC) to rollout out a series of trainings and technical assistance efforts to promote clarification of standards;
- Work with provider trade associations to review its Community Based Behavioral Services (CBS) fee schedule and implement any simplifications that can be achieved; and
- Clarify its requirements related to third party liability (TPL) and seek to implement policy simplifications when possible.

3. Certification and Licensure of Behavioral Health Providers



Issue: Behavioral health providers face delays and administrative burden due to fragmented certification, licensure, and Medicaid enrollment processes across IHHS departments and MCOs.

Overview:

Providers expressed concerns regarding the certification, licensure, and enrollment processes utilized by IHHS departments. Understanding the overall importance of Medicaid in sustaining the behavioral health system, providers underscored their challenges and experience with HFS' IMPACT system, focusing primarily on two issues: 1) processing lag of applications; 2) a general lack of "push notifications" updating providers on status (requiring someone to log in and actively monitor application status); and 3) inconsistent and delayed communication from IMPACT. Additionally, providers expressed that challenges with certification and licensure grew proportionally with provider efforts to expand care. Provider organizations seeking to enroll to provide different types of service (e.g. SUD services, developmental disability services, physician/nurse practitioner services) experienced increased frustration as they experienced process fragmentation and lengthier lag times, as different entities reviewed applications, performed on-site reviews, or issued licensure. Additionally, within the certification regulations and review processes, providers identified key sticking points, specifically: 1) State Fire Marshal inspection requirements; 2) DCFS background check requirements; and 3) challenges with staff training, both inconsistent requirements across regulations and onerous manual tracking of training compliance. Providers also noted that the Medicaid enrollment process was further aggravated by contracting

and onboarding the HFS-contracted MCOs, adding additional navigation inefficiencies to an already long and challenging process.

Examples of this challenge include:

- Fragmented and lengthy credentialing and enrollment and processes between IHHS departments
- Delays in DCFS background checks often force organizations to delay the onboarding of new employees
- Requirements for State Fire Marshal inspections cause significant delays in opening new clinics
- Inconsistent and difficult to track training requirements across different State payers

Impact to providers:

- Delays in opening new clinics have significant financial ramifications and impact service access for clients
- Providers struggle to achieve operational efficiency caused by inconsistent requirements across State Departments and MCOs
- Providers are required to manually track and demonstrate employee compliance with mandated training to receive and maintain approval to deliver certain services, increasing administrative burden and costs of management

Recommendations:

IHHS Departments reconvene the State's interagency Medicaid workgroup to review and support streamlining of regulatory structures. This work should include:

- Alignment and integration with ongoing efforts to identify gaps in certification, licensure and oversight for behavioral health providers being led by the CBHO;
- Development of a crosswalk behavioral health provider credentialling and licensing requirements and identify areas for improvement;
- Evaluate opportunities for streamlining the credentialing of providers seeking to provide mental health and SU services;
- Evaluate the current background check requirements and process to identify efficiencies and decrease wait time for new hires; and
- Evaluate the Fire Marshal requirements, including those found in 405 ILCS 30/3.5 and 59 ILAC 132, to identify opportunities for efficiency that could shorten the current process delays experienced by providers. It is important to note that while streamlining processes and improving efficiency are important, maintaining safety remains the most critical priority. Finally, it is recommended that HFS review it's general IMPACT processes related to behavioral health provider types and identify opportunities to strengthen and streamline certification and enrollment processes. This may include increasing coordination and training amongst IHHS departments, as well as working in partnership with the MTAC to ensure training and technical assistance on certification and enrollment processes are available for existing and prospective providers of behavioral health services.

4. Integrated Behavioral Health Service Delivery

Issue: Providers delivering both mental health and SUD services face fragmented and inconsistent state administrative and practice requirements, creating regulatory burden, inefficiencies in clinical care, and barriers to delivering integrated, holistic behavioral health services.

Overview.
Given the well documented rate of co-occurrence between mental health and SUDs, providers understand the importance of providing holistic care to clients but find it difficult to navigate the separate administrative and practice requirements established by the State. To ensure client needs are met, providers often must find "in-house" ways to merge mental health and substance use treatment under both grant and Medicaid payment frameworks. This behavioral health integration challenge impacts provider operations and potentially limits access to care.

Examples of this challenge include:

- Compliance with multiple state regulations (i.e. legacy SUPR 2060/2090, DMH Rule 132, and HFS Rule 140 requirements)
- Compliance with multiple handbook and policy requirements issued by different agencies addressing similar topics
- No integration between American Society of Addiction Medicine (ASAM) criteria and the mental health Integrated Assessment and Treatment Planning (IATP) requirements

Impact to providers:

- Increased provider cost and effort to ensure organizational compliance
- Impacts to clinical practice creating inefficiencies and limiting client throughput

Recommendations:
Through the merger of the Divisions of Substance Use Prevention and Recovery (SUPR) and Mental Health (DMH) into the Division of Behavioral Health and Recovery (DBHR), as well as the State's implementation of Certified Community Behavioral Health Clinics (CCBHCs), IHHS Departments recognize the importance of advancing and expanding access to integrated behavioral health care.

To build on these efforts and reduce the complexity experienced by providers seeking to deliver integrated behavioral health services, it is recommended that the State extend the work product of ABTF be establishing a workgroup focused on integrated care practice. This workgroup should be co-led by IDHS and HFS, supported by other IHHS Departments as appropriate, and include meaningful stakeholder participation.

The purpose of this workgroup would be to identify and address challenges faced by provider organizations delivering integrated mental health and substance use disorder services. Using Illinois' CCBHC demonstration as a model of what is possible, the workgroup should focus on streamlining service requirements across mental health and substance use treatment systems. A more aligned, streamlined approach to community-based mental health and substance use service delivery will promote increased access to care for clients while reducing administrative burden for providers.

A specific focus of this workgroup should include evaluating opportunities to integrate substance use and mental health assessment and treatment planning processes, including alignment between Medicaid's Integrated Assessment and Treatment Plan (IATP) requirements and the American Society of Addiction Medicine (ASAM) criteria.

5. Behavioral Health Crisis Services Funding

Issue: Illinois' mobile crisis response system relies on parallel Medicaid-funded and grant-based program structures that are not fully aligned, creating administrative and financial challenges for providers while potentially undermining the scalability and sustainability of crisis services.

Overview:
A subset of providers across Illinois comprises the State's two primary mobile crisis response networks, one serving primarily adults and the other focused predominantly on children. These providers deliver critical community-based interventions that provide support to individuals in the height of a behavioral health crisis.

All crisis response providers must obtain specialized certification from HFS to receive Medicaid reimbursement, while a portion of the system continues to operate primarily under grant-based funding administered by IDHS. Although differences between the State's Medicaid-funded and grant-based crisis programs may appear modest at the policy level, providers report that navigating these parallel systems creates substantial operational complexity, inconsistent program expectations, and increased administrative cost. This absence of private insurance reimbursement for crisis services further compounds operational complexity by limiting providers' ability to offset administrative costs and stabilize funding across the crisis continuum.

Under the grant-based model, providers are required to maintain specialized roles, such as Peer Engagement Specialists, that have not historically been reimbursable under Illinois Medicaid. Conversely, the Medicaid-funded crisis model emphasizes clinically driven stabilization services delivered in the community, with strict documentation and time-tracking requirements to support billing of the initial crisis service (60 minutes) and then requires transition and subsequent service billing in fifteen-minute increments.

While these two funding and operational models collectively form Illinois' crisis response safety net, the lack of alignment between them weakens system cohesion and places unnecessary strain on providers, resulting in a crisis continuum that is more fractured than intended.

Examples of this challenge include:

- Differences between grant-funded and Medicaid-funded crisis requirements creates confusion and increases provider cost of operation
- Grant-based service delivery requires team-based response and the inclusion of peer staff that are unique to crisis and certain team-based services under the Illinois Medicaid program contributing to provider workforce issues
- Providers seeking to integrate crisis services programs across a single team are required to manage complex cost allocation strategies to maintain financial integrity of grant and Medicaid financial requirements

Impact to providers:

- Providers must navigate multiple, misaligned funding and oversight frameworks (i.e. grant-based and Medicaid), each with distinct staffing models, documentation standards, and compliance requirements. This complexity diverts leadership and clinical staff time away from direct service delivery.
- Differences in reimbursable models and service structures create funding gaps that providers must absorb or cross-subsidize, undermining financial sustainability.
- The complexity and cost of operating across two systems discourages provider participation and expansion, weakening network capacity and contributing to fragility in the crisis response continuum.

Recommendations:

In 2023, working under the leadership of the Governor's Office, IDHS and HFS began the development of Illinois' Unified Crisis Continuum (UCC). Utilizing's Substance Abuse and Mental Health Services Administration (SAMHSA)'s framework[ix] for providing crisis service: 1) someone to call; 2) someone to respond; 3) a safe place to go – Illinois' UCC initiative seeks to streamline access to crisis services in Illinois. While the IHHS departments continue to transition parts of the State's existing crisis infrastructure to achieve SAMHSA's framework for a strong statewide crisis program, interagency collaboration has led to significant planning and progress towards these aims.

It is recommended that the IHHS Departments continue collaboratively to strengthen the State's crisis safety net by:

- Introducing an updated Medicaid-based service delivery framework that simplifies current protocols that necessitate the billing of multiple service activities during a crisis response by introducing a bundled reimbursement methodology;
- Improve the alignment between Illinois' state-funded, grant-based crisis program and its Medicaid-funded crisis service requirements to ensure sustainability of the program through Medicaid maximization and targeted utilization of scarce state funds.
- Promote a "No wrong door" model of service access, building upon the State's 988 call centers and work to streamline dispatch of crisis response services across the state.
- Consider strategies that promote parity in the financing of crisis services across all payers, reducing the state's overall liability for care when customers have private insurance.

6. Monitoring and Oversight of Behavioral Health Providers

6

Issue: Behavioral health providers experience increased administrative burden due to duplicative, uncoordinated, and inconsistent oversight, monitoring, auditing, and reporting requirements.

Overview:

Providers consistently identified operational challenges with what they perceived to be duplicative oversight, monitoring, and auditing requirements from the IHHS departments and their agents, including HFS-contracted MCOs. Such oversight was inclusive of grant and programmatic monitoring, financial and program auditing, provider recertification reviews, accreditation requirements, ad hoc data reporting requests, and other similar efforts by the State. Providers expressed that processes were repetitive while

[ix] https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care

frequent ad hoc requests for reporting and information from payers were onerous. Finally, many providers invest in external accreditation bodies (e.g. The Joint Commission, CARF) and expressed the potential benefits that could be experienced if good standing with an accrediting agency could be leveraged in the various State oversight processes.

Examples of this challenge include:

- Providers experience duplicative and time intensive audit and oversight across IHHS departments and MCOs
- MCOs and State partners frequently request data and reporting, including ad hoc information, eroding staff and management time
- Providers report a lack of standardized grant monitoring practices among IHHS departments

Impact to providers:

- While some oversight is necessary to ensure program integrity, multiple oversight touchpoints and fragmented review increase provider compliance costs
- Decentralized oversight contributes to unclear or conflicting guidance to providers, undermines operational efficiency, and contributes to relationship issues between providers and IHHS department staff

Recommendations:

It is recommended that the reconvened interagency Medicaid workgroup (as identified in recommendation 3):

- Work with CBHO staff and a sample of providers to identify oversight bodies experienced by a cross-section of behavioral health provider types;
- Review all known monitoring, audit, and recertification procedures across HFS and IDHS to identify opportunities to streamline provider touchpoints;
- Review Section 132.120 – Deemed Status of 59 ILAC 132 to identify any opportunities to simplify oversight operations;
- Explore to the possibility of centralizing State oversight operations across all IHHS departments; and
- Review agency and agent ad hoc data requests from providers to determine the feasibility of standardizing requests on a known schedule.

Additionally, the IHHS departments should work to improve the training and consistency among monitoring and auditing staff. This effort will improve behavioral health provider experience, making oversight engagements feel less arbitrary and promote stronger partnership between the providers and IHHS departments.

7. Data Collection, Submissions and Reporting

Issue: Behavioral Health providers struggle to meet state data submission and reporting requirements due to inconsistent data definitions, reporting standards, and technology across multiple state and federal agencies, resulting in increased administrative burden and costs.

Overview.

Providers express concern meeting State data submission and reporting requirements. This concern stems from

inconsistencies in data reporting requirements required to satisfy data needs from both federal and IHHS departments. This issue highlights the residual impacts of behavioral health service delivery being organized by disparate and siloed funding streams (or programs) being administered across multiple IHHS departments. Historically, each of these agencies independently established data definitions and reporting standards in regulation and policy and codified these decisions in operating procedures that are now difficult to change due to legacy data reporting platforms.

Examples of this challenge include:

- Different definitions for similar data elements across IHHS departments
- Different approaches to track client service delivery through registration and service enrollment processes

Impact to providers:

- Increased effort to ensure adequate data collection
- Difficulties in standardizing data elements across funders
- Increased cost related to management of electronic health record systems

Recommendations:

Continuing to build upon the ABTF work product, it is recommended that an interagency data workgroup, led by IDHS and HFS, be established to review all provider data submission requirements and platforms. The data workgroup will seek consultation from providers and other stakeholders to ensure continued understanding of daily needs and operations. Though initial efforts should focus on existing requirements with the focus of seeking to standardize data elements and eliminate legacy data collection that is no longer necessary, long-term efforts should seek to establish standard to streamline data entry systems for providers.

8. Technology Enhancements

Issue: Behavioral health providers must navigate multiple state-administered data systems that are often outdated, poorly integrated, and misaligned with provider technology capacity, resulting in administrative burden, limited interoperability, and minimal operational value from required data reporting.

Overview.

Each state agency administers its own set of data systems that providers are required to interface with to perform functions such as eligibility verification, claims submission, data reporting, etc. While some providers still require access to direct data entry portals other providers have more sophisticated electronic health infrastructure that could more easily push information to the state increasing efficiency and operations. As the State's electronic infrastructure continues to age, legacy systems can create administrative challenges for behavioral health providers of varying technical capacity. And while some IHHS departments have begun to introduce newer, modern technologies (e.g. HFS' rollout of IMPACT, introduction of MCO technical platforms, IDHS' plan to update its DARTs system), technical migration efforts can be protracted and behavioral health provider system capacity is often not considered in the design or development of State technologies. Providers identified specific issues with legacy systems (such as IDHS' DARTS and HFS' MEDI systems) and newer implementations such as HFS' IMPACT system. In sum, providers experience state technology platforms as a

burden– often requiring manual efforts to enter data with limited output or reporting available to help support provider practice.

Examples of this challenge include:

- Providers are unable to identify service details such as lead providers of case management services
- SUD providers highlighted challenges interfacing with the DARTS system
- Concerns regarding HFS' MEDI system focus on its JAVA design leading to limited interoperability with provider technology
- Limited interoperability between provider technology systems and outdated State systems when possible

Impact to providers:

- As behavioral health providers continue to introduce fully functional electronic health records within their practice to gain efficiencies in operations the limited plug-and-play interoperability of existing State systems requires providers with greater technical capacity to still allocate administrative resources to manually interfaces.
- Providers invest time and staff resources to input data and information into State systems but providers are unable to capitalize on the value in the process as there are limited feedback loops and outputs available to them.

Recommendations:

Understanding the challenges of existing technology and fiscal constraints of overhauling the state's technical infrastructure, it is recommended that:

- IHHS departments continue to review their technical platforms with providers.
- Understanding that implementing updated State technical platforms can take years to develop and implement, establishing a communications feedback loop with provider users of legacy platforms is necessary to ensure technical problems do not go unnoticed or unresolved for extended periods of time.
- When possible, State technical system updates should be undertaken with provider working groups and piloted before rolling out to the larger behavioral health system.
- IHHS Departments make continuous investments in modernizing legacy technical platforms supporting the state's behavioral health system.

9. Provider-to-Payer Communications

Issue: Inconsistent, untimely, and fragmented communications from IHHS departments and Medicaid MCOs creates confusion for behavioral health providers, increases administrative burden, compliance risk, and operational disruption, particularly when policy changes require rapid technical system updates.

Overview.

Providers receive communications in varying formats and frequencies from IHHS departments and MCOs, which serve as critical updates on ongoing work, program and service changes, policies and procedures, and new opportunities. Providers experience inconsistencies in messaging between and within the IHHS

departments and MCOs. These inconsistencies can result in conflicting information, missed updates and confusion, resulting in non-compliance, delays and missed opportunities. Providers are seeking transparency and timely communication from IHHS departments and payors to support operational stability. A specific challenge arises when policy or procedural changes require modifications to provider technical systems, which is common, yet providers often lack sufficient time to implement these changes effectively.

Examples of this challenge include:

- Receiving information that requires technical system updates without adequate time to implement
- Conflicting or unclear guidance from IHHS departments
- Missing key updates, such as an informational meeting, learned later from provider colleagues and Trade associations
- Delayed responses to provider inquiries, including acknowledgement of receipt

Impact to providers:

- Current communication challenges can lead to operational inefficiencies and added administrative burden from reconciling conflicting information
- Providers experience increased risk of non-compliance, creating the potential of penalties or delayed reimbursement
- Providers experience unexpected costs resulting from policy changes that require them to implement changes to their electronic systems rapidly and without notice
- Misunderstanding of program requirements, causing frustration and strained relationships with State partners.

Recommendations:

- IHHS departments should consider provider communication as an essential implementation element of all programming changes and when possible, over-communicate about upcoming changes via informational meetings and webinars;
- IHHS departments also should adopt a practice of sharing provider notices and external communications with each other to pollinate cross-communication and continuity for providers.
- IHHS departments should also make efforts to ensure communication is timely, especially as it relates to critical updates and information. Departments should also consider posting critical updates on an online forum to support efficient dissemination.
- Utilize forums such as the Medicaid Advisory Committee, and its subcommittee meetings, to highlight recent changes in MCO policy or.
- Educate providers about the MCOs requirements to communicate with and offer education and technical assistance for its contracted providers on operational policy and procedures.
- IHHS departments should, when possible, rollout out programmatic and technical updates to providers on a standardized schedule that would promote greater planning and recognizes the time lag it takes for providers to update their systems.

Additionally, as an immediate attempt to improve access to information, the CBHO will establish a centralized web resources to act as an index of current behavioral health regulations, handbooks, and vital self-sign up communication platforms). An effort that will be managed in collaboration with the CBHO newsletter to help support and highlight policy updates for providers.

Conclusion

This report was prepared by Dr. Inger Burnett-Zeigler, Illinois' Chief Behavioral Health Officer, to document the ABTF process and its findings. Certain issues and topics raised during the ABTF process that are not addressed in this report have been referred to other IHHS departments for further consideration. The work undertaken by the ABTF represents an important first step in identifying administrative burdens that affect access to care, workforce retention, and related challenges impacting provider's focus on delivering high quality, client-centered care. IHHS Departments are encouraged to continue engaging in dialogue around the recommendations outlined above and to build upon the work of the committed members of the ABTF. Questions or comments regarding this report may be directed to:
OMI.CBHO@uillinos.edu

Appendix

Acronym Glossary

Acronym	Definition
ABTF	Administrative Burden Task Force
ASAM	American Society of Addiction Medicine
BHC	Behavioral Health Clinic
CARF	Commission on Accreditation of Rehabilitation Facilities
CBHO	Chief Behavioral Health Officer
CBS	Community Based Behavioral Service
CCBHC	Certified Community Behavioral health Clinic
CMHC	Community Mental Health Center
CSB	Community Service Board
DART	Division's Automated Reporting & Tracking System
DCFS	Department of Children and Family Services
HB	House Bill
HFS	Illinois Department of Healthcare and Family Services
IATP	Integrated Assessment and Treatment Planning
IDHS - DMH	Illinois Department of Human Services' Division of Mental Health
IDHS - SUPR	Illinois Department of Human Services' Substance Use Prevention & Recovery
IDHS-DBHR	Illinois Department of Human Services' Division of Behavioral Health & Recovery
IDPH	Illinois Department of Public Health
IHHS	Illinois Health and Human Services
IMPACT	Illinois Medicaid Program Advanced Cloud Technology
MCO	Managed Care Organization
MEDI	Medicaid Electronic Data Interchange
MTAC	Medicaid Technical Assistance Center
OMI	Office of Medicaid Innovation
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder
TPL	Third-Payer Liability
UCC	Unified Crisis Continuum

List of Administrative Burden Task Force Members

First Name	Last Name	Title	Organization	Affiliation
Heather	Ast	Associate Assistant to the Director Prevention Child Protection & SCR	Illinois Department of Children and Family Services (Services (DCFS)	Representative from the Department of Children and Family Services
Chris	Balkema	Senator	Illinois Senate Republicans	One member of the Senate, appointed by the Senate Minority Leader
Stephanie	Barisch	Director of Therapeutic Services	Center for Youth and Family Solutions	Community mental health and substance use provider representing geographical regions across Illinois
Kerri	Brown	Chief Executive Officer	Community Counseling Centers of Chicago (C4)	Community mental health and substance use provider representing geographical regions across Illinois
Dr. Inger	Burnett-Zeigler	Chief Behavioral Health Officer	Office of The Illinois Governor J.B. Pritzker	Task Force Chair
Blanca	Campos	Chief Executive Officer	Community Behavioral Healthcare Association (CBHA)	Representatives of statewide associations that represent behavioral health providers
Lori	Carnahan	Deputy Director, Behavioral Health	DuPage County Health Department	Community mental health and substance use provider representing geographical regions across Illinois
Dr. Catherine	Counard	Preventative Medicine Medical Advisor	Illinois Department of Public Health (IDPH)	Representative from the Department of Public Health
Sarah	Daniels	Chief of Staff	Illinois Collaboration on Youth (ICOY)	Representatives of statewide associations that represent behavioral health providers
Kelly	Epperson	Chief of Staff	Rosecrance	Community mental health and substance use provider representing geographical regions across Illinois
Laura	Fine	Senator	Illinois Senate Democrats	One member of the Senate, appointed by the Senate President
Lauren	Finnegan	Director of Behavioral Health Services	Metropolitan Family Services	Community mental health and substance use provider representing geographical regions across Illinois
Laura	Garcia	Medicaid Liaison	Illinois Department of Human Services (IDHS) – Division of Behavioral Health and Recovery (DBHR)	Representative from the Division of Substance Use Prevention and Recovery in the Department of Human Services
Mary	Garrison	President and Chief Executive Officer	Heritage Behavioral Health	Community mental health and substance use provider representing geographical regions across Illinois
Jackie	Haas	Representative	Illinois House Republican	One member of the House of Representatives, appointed by the Minority Leader of the House

Brenda	Hampton	Director of Community Linkages	University of Illinois at Chicago Crisis Hub	University Partnership
Kristine	Herman	Bureau Chief of Behavioral Health	Illinois Department of Healthcare and Family Services (HFS)	Department of Healthcare and Family Services
Eugene	Humphrey	Executive Director	Human Resources Development Institute (HRDI)	Community mental health and substance use provider representing geographical regions across Illinois
Lindsey	LaPointe	Representative	Illinois House Democrat	Task Force Co-Chair One member of the House of Representatives, appointed by the Speaker of the House
Lynn	Mathews (O'Dell)	Executive Director	Community Resource & Counseling Center	Community mental health and substance use provider representing geographical regions across Illinois
Bernadette	May	Chief Operations Officer	Family Service Association (FSA) of Greater Elgin	Community mental health and substance use provider representing geographical regions across Illinois
Jen[x]	McGowan-Tomke	Chief Operating Officer	Formerly NAMI Chicago	Representatives of advocacy organizations either led by or consisting primarily of individuals with lived experience
Darius	McKinney	Deputy Director of Community Programs	Illinois Department of Human Services (IDHS) – Division of Behavioral Health and Recovery (DBHR)	Representative from the Division of Mental Health in the Department of Human Services
Emily	Miller	Senior Vice President Policy and Advocacy	Illinois Association of Rehabilitation Facilities (IARF)	Representatives of statewide associations that represent behavioral health providers
Dr. Forrest	Moore	Policy Fellow	University of Chicago, Chapin Hall	University Partnership
Cris	Mugrage	Director Quality Assurance and Corporate Compliance	Sinnissippi Centers	Community mental health and substance use provider representing geographical regions across Illinois
Eileen	Nicollai	Senior Vice President, Clinical Operations	Thresholds	Community mental health and substance use provider representing geographical regions across Illinois
Julie	Noobler	Director of Mental Health and Wellness	Brightpoint	Community mental health and substance use provider representing geographical regions across Illinois
Meredith	O'Brien	Vice President of Public Policy and Training	Illinois Association for Behavioral Health (IABH)	Representatives of statewide associations that represent behavioral health providers

[x] Jen McGowan-Tomke, a former Task Force member, resigned in July 2025 due to resigning from her organization. Jennifer was succeeded by Kathy Ziecik from the same organization.

Mansi*[xi]	Patel	Chief Operations Officer	Family Service Association of Greater Elgin	Community mental health and substance use provider representing geographical regions across Illinois
Matt	Pickett	Health Policy Coordinator	Illinois Department of Insurance (DOI)	Department of Insurance
Dr. Mary	Roberson	Chief Executive Officer	Northern Illinois Recovery Community Organization (NIRCO) *Representing Illinois Harm Reduction Recovery Coalition*	Representatives of advocacy organizations either led by or consisting primarily of individuals with lived experience
Mark	Schmitz	Executive Director	Transitions of Western Illinois (TWI)	Community mental health and substance use provider representing geographical regions across Illinois
Matthew	Stinson	Associate Director	University of Illinois Urbana- Champaign – Provider Assistance Technical Hub	University Partnership
Anne	Tyree	Regional Chief Executive Officer	Centerstone	Community mental health and substance use provider representing geographical regions across Illinois
Dr. Dana	Weiner	Chief Officer for Children's Behavioral Health	Office of the Illinois Governor J.B. Pritzker	Department of Children and Family Services
Dr. Kari	Wolf	Chief Executive Officer	SIU School of Medicine's Behavioral Health Workforce Center	University Partnership
Kathy	Ziecik	Director of Care Coordination	NAMI Chicago	Representatives of advocacy organizations either led by or consisting primarily of individuals with lived experience

Meeting Materials and Reference Links

Additional information, including agendas, meeting notes, and task force membership, is available on the Behavioral Health Administrative Burden Task Force page: IDHS: Behavioral Health Administrative Burden Task Force

[xi] Mansi Patel, a former Task Force member, resigned in August 2025 due to resigning from her organization. Mansi was succeeded by Bernadette May from the same organization.